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APPENDICES

MIChild is a health coverage program using State funds as well as funds authorized under Title XXI of the Federal Social Security Act to furnish health care coverage to a targeted population. This population consists of individuals under age 19 who are not eligible for Medicaid, whose family income is above 150% and at or below 200% of the federal poverty level, and who do not have health coverage.

HEALTH PLANS

The Department contracts with health plans to provide services to *MIChild* beneficiaries. Plans are reimbursed on a per member per month capitation basis and are responsible for activities including:

- provision of most services, as determined by the Department (dental services, mental health services and substance abuse services are explained below)
- reimbursement for direct care and subcontracted providers
- maintenance of records as determined by the Department.

Health plans may also make an initial determination of *MIChild* eligibility. The final determination is made by the Department.

DENTAL PLANS

The Department contracts with dental plans to provide covered dental services to *MIChild* beneficiaries on a per member per month capitation basis.

The dental plans have the same responsibilities as the health plans except the dental plans do not make initial determinations of *MIChild* eligibility. Enrollment in the dental plans occurs through the Administrative Contractor.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The Department contracts with local community mental health service plan (CMHSP) to provide all mental health and substance abuse services to *MIChild* beneficiaries on a per eligible per month capitation basis. Beneficiaries do NOT enroll with the CMHSP to receive services, but are referred to them by the health plans. The CMHSPs are responsible for:

- provision of mental health services, as determined by the Department

- reimbursement for direct care and subcontracted providers
- maintenance of records as determined by the Department.

The CMHSP will not make initial determinations of *MIChild* eligibility.

ADMINISTRATIVE CONTRACTOR

The Department of Community Health contracts with an Administrative Contractor to provide administrative support for *MIChild*.

The Administrative Contractor is responsible for activities including:

- eligibility recommendations, with the Department granting final approval of eligibility
- enrollment/disenrollment in the health and dental plans chosen by the beneficiary's family
- maintenance of records as determined by the Department
- verification of enrollment and membership in health and dental plans
- collection of monthly premiums from the family
- monitoring the health and dental plans as determined by the Department
- operating a telephone bank to answer beneficiary/public questions about eligibility, applications, enrollments and related matters.

There are some applicants who may be eligible for, or enrolled in, other federal-state programs. These applicants may also be eligible for *MIChild*.

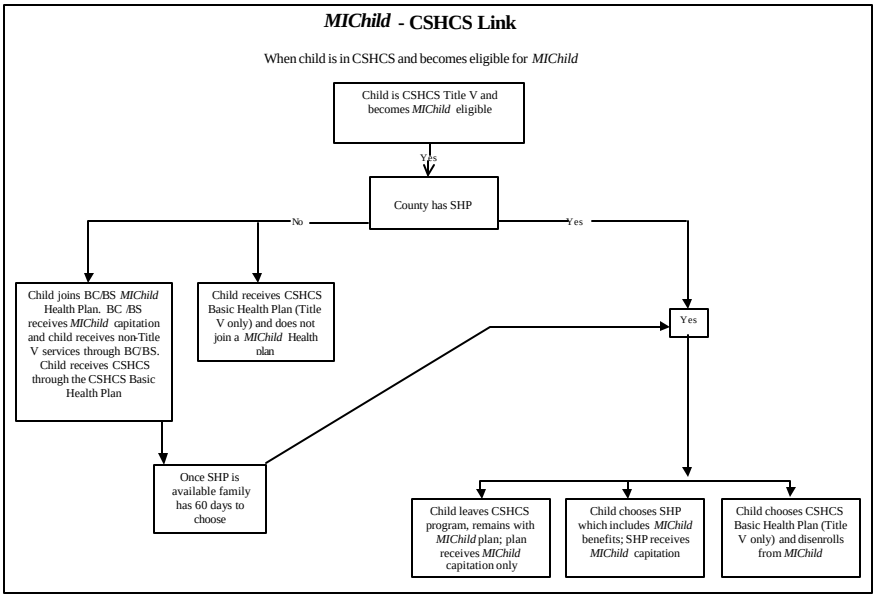
CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS) ONLY APPLICANTS

Applicants with CSHCS coverage who become eligible for *MIChild* or applicants with *MIChild* coverage who become eligible for CSHCS have the following options:

- a child can be in CSHCS and *MIChild*. The child must either enroll in a Special Health Plan (SHP) (if one is available) or Blue Cross/Blue Shield (BC/BS) if no SHP is available, or;
- The child can elect not to receive *MIChild* coverage and maintain CSHCS only benefits through the CSHCS Basic Health Plan, or;
- The child can elect to receive *MIChild* coverage only and enroll in the *MIChild* Health Plan of their choice. CSHCS coverage will be terminated.

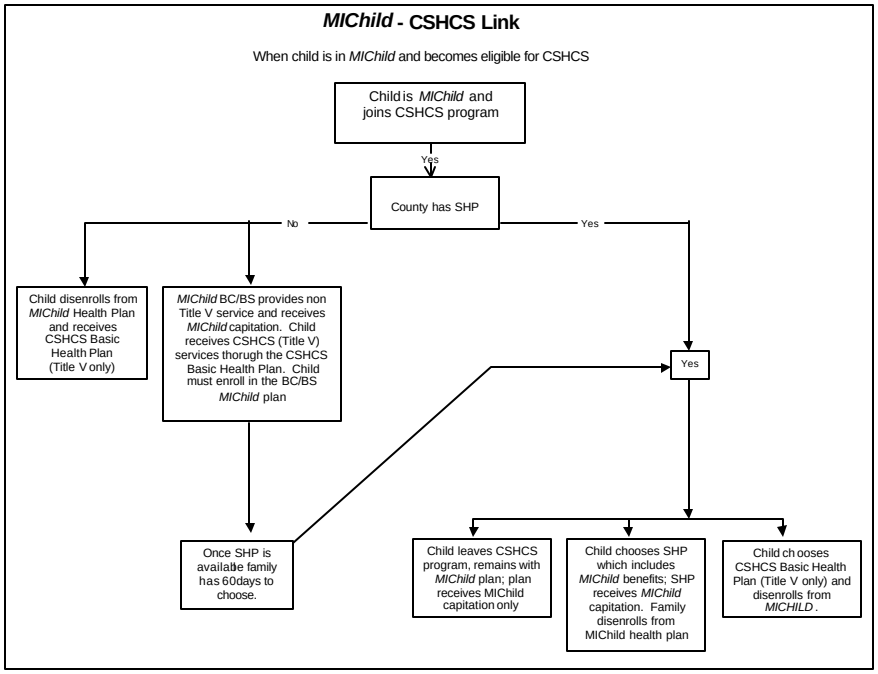
For applicants choosing to have both *MIChild* and CSHCS benefits who live in a county without a SHP, BC/BS coordinates services with CSHCS. In counties with a SHP option, the SHP coordinates *MIChild* and CSHCS coverages.

If the *MIChild* beneficiary has CSHCS and elects to choose a health plan other than that which will allow both *MIChild* and CSHCS coverages to continue, the CSHCS coverage will end.



Applicants enrolled in *MIChild* and CSHCS who live in a county where a SHP is or becomes available must make a choice from the following options within 60 days:

- The child can disenroll from the *MIChild* plan and enroll in the SHP to receive all the *MIChild* and CSHCS covered services through the SHP, or;
- The child can choose to receive only CSHCS coverage through the CSHCS Basic Health Plan. The child will be disenrolled from *MIChild*, or;
- The child can choose *MIChild* coverage only and disenroll from the CSHCS program.



MIChild beneficiaries with CSHCS coverage who are enrolled in a SHP may choose to switch between the SHPs if both are available within the beneficiary's county of residence.

TMA-PLUS

TMA-Plus (Transitional Medical Assistance-Plus) is a program operated by the State for persons losing coverage under either the Medicaid program Transitional Medicaid Assistance (TMA) or the State-operated Michigan TMA (MTMA) coverage program. TMA-Plus allows families who have worked their way off cash assistance to continue health care coverage if no employer coverage is offered or the cost of employer coverage is more than the TMA-Plus premium. TMA-Plus is only available to families whose income is at or below 185% of the FPL.

A family may be eligible for TMA-Plus and *MIChild*. The children will be either Healthy Kids/Medicaid or *MIChild* eligible. The family may choose to obtain the adult's coverage using TMA-Plus.

- The family may purchase TMA-Plus coverage for children at the TMA-Plus premium, or
- The family may purchase *MIChild* coverage for the children at the *MIChild* premium. There is no six-month waiting period for *MIChild* benefits.

COURT-ORDERED MEDICAL INSURANCE

There are situations when the noncustodial parent/guardian has not provided court-ordered medical insurance. In these situations, the child may be enrolled in *MIChild*. The custodial parent/guardian must be advised that he must pursue the court-ordered insurance.

- Any beneficiary with comprehensive health insurance must be disenrolled from *MIChild*.
- If the noncustodial parent/guardian is still in the process of obtaining comprehensive health insurance, the child may enroll in, or remain on, *MIChild*.
- If the custodial parent/guardian has not pursued the court-ordered medical insurance, the child must not be enrolled in, or remain on, *MIChild*.

SPEND-DOWN APPLICANTS

A family may be required to meet a spend-down amount to become Medicaid eligible. In these situations:

- The child may be *MIChild* eligible.
- The incurred medical expenses of anyone in the child's fiscal group may used to meet the spend-down amount.
- When the spend-down is met, children on *MIChild* are not to be disenrolled from *MIChild.*
- Once the child is Medicaid eligible, *MIChild* will be considered a third party resource to be billed prior to billing Medicaid. Medical Services Administration (MSA) will reconcile the payments in an internal process.

NEWBORN ELIGIBILITY

The newborn in a family whose mother is already receiving Medicaid for the month of birth is eligible for Medicaid for one year. In these cases, the newborn must not be enrolled in *MIChild.*

A family may not receive *MIChild* benefits for any member who is Medicaid eligible, other than spend-down applicants. If determined eligible for Medicaid, the children must be disenrolled from *MIChild,* effective the last day of the month prior to the month that Medicaid begins so there is no break in health coverage for the children.

Newborns of Dependent Children

- If a beneficiary already enrolled in *MIChild* gives birth, the newborn's fiscal group will have to be redetermined using only the mother and the newborn in the fiscal group. Both the mother and the newborn will usually be Healthy Kids/Medicaid eligible. A new *MIChild/*Healthy Kids application must be submitted.
- If the unborn child was included in the original determination of the fiscal group and the income for the fiscal group is equal to or less than 185% of the FPL, the newborn would be Healthy Kids eligible until age 1. The other children currently on *MIChild* would remain on *MIChild*. The entire group retains the redetermination date of the original group.

- If the unborn child was included in the original determination of the fiscal group and the income for the fiscal group is more than 185% of FPL, the newborn would be *MIChild* eligible. The other children currently on *MIChild* would remain on *MIChild*. The entire group retains the redetermination date of the original group.

- If the unborn child was NOT included in the original determination of the fiscal group, the addition of one new fiscal group member will always make the newborn Healthy Kids eligible. The other children may remain *MIChild*, until re-evaluated at redetermination. A new application must be submitted for the newborn.

RETROACTIVE MEDICAID

There may be cases where the *MIChild* beneficiary obtains Medicaid coverage for the same time period as *MIChild* eligibility. In these situations, the beneficiary should be disenrolled from *MIChild* as soon as he is identified as being Medicaid eligible, effective the first of the month following identification of Medicaid. A beneficiary enrolled in *MIChild* cannot be retroactively disenrolled from *MIChild*.

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Eligibility for *MIChild* must be based on the following criteria. Verifications for each criterion are included.

CITIZENSHIP

The applicant must be a citizen of the United States or a documented alien. Some legal immigrants are not eligible for *MIChild* for the first five years of residency. Legal immigrants who are eligible in the first five years of residency include refugees and children of veterans.

VERIFICATION:

If the child is a United States citizen, the applicant's or responsible relative's statement of citizenship is verification.

Alien status can be verified by:

- the Alien Registration Card (I-551). Appendix A contains alien status codes that appear on the I-551 and their impact on *MIChild* eligibility.
- I-94 form stamped "Processed for I-551," or "Cuban/Haitian Entrant (Status Pending)," "parole," "212 (d) (5)," or "Form I-589 Filed."
- I-94 form indicating admission into the United States from Cuba or Haiti and letter or notice from the Immigration and Naturalization Services (INS) indicating ongoing (not final) deportation, exclusion, or removal proceedings.
- Passport stamped "Processed for I-551 Temporary Evidence of Lawful Admission for Permanent Residence."

Any other notations on the I-94 or other forms (e.g., visa) are not acceptable and the child is not eligible for *MIChild.*

RESIDENCY

The applicant must be a resident of the State of Michigan.

A person is considered a resident if he lives in Michigan **and** intends to remain in Michigan permanently or indefinitely.

Children in a family that comes to Michigan with the intent to work (e.g., migrants) are eligible for *MIChild* benefits, provided all other eligibility requirements are met.

VERIFICATION:

The applicant's or responsible relative's statement of intent to remain, or work, in Michigan is verification of Michigan residency.

If the applicant is leaving Michigan for more than 30 days but intends to return to Michigan, then intent to remain a resident must still be verified. Such verification could include proof that utility bills, rent, or property taxes are currently being paid.

SOCIAL SECURITY NUMBER

All applicants, except newborns, must have a Social Security Number (SSN), or an application for an SSN must have been filed. SSNs are not required for the parents unless they are also applying for medical benefits for themselves.

VERIFICATION:

The family must provide the SSN, SSN application, or verification from the hospital that a request for an SSN has been made for a newborn. The applicant's statement of their SSN is acceptable verification.

Each child must have obtained a SSN by annual redetermination.

AGE

The applicant must be between 0 and 19 years of age. *MIChild* coverage ends the last day of the month in which the child turns 19.

VERIFICATION:

The applicant's or responsible relative's statement of the child's age is verification of the age criteria. In addition, the applicant's date of birth must be entered on the *MIChild* application.

INSURANCE COVERAGE

The applicant must not:

- be currently covered under a comprehensive health insurance policy (group or private), or
- have had comprehensive employer-based health insurance in the past six months, including Medicare, with exception allowed for non-voluntary loss of insurance. Applicants will not be eligible for coverage until the seventh month after the employer-based coverage ends. Applications received within 90 days of the eligible month will be processed for coverage, if otherwise

eligible, beginning the seventh month. Chapter XIII, DEFINITIONS, contains a definition of non-voluntary loss of insurance.

Specialty insurance coverage such as dental-only or catastrophic-only coverage is not considered comprehensive health insurance.

Coverage through the CSHCS program or the Native American Health Services is not to be considered comprehensive health insurance for eligibility purposes.

VERIFICATION:

The applicant's or responsible relative's written statement attesting to all the above is verification.

ASSETS

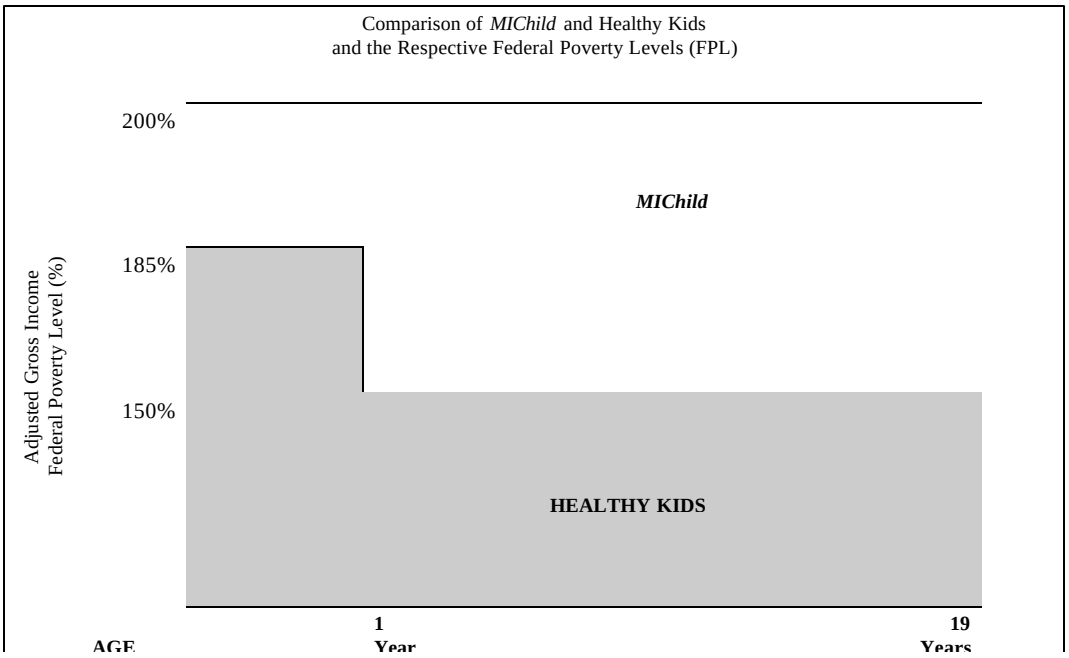
No asset test is used.

INCOME

The adjusted gross income must be above 150% and at or below 200% of the FPL, depending on the child's age.

- For children age 1 year to 19 years of age, the adjusted gross income must be above 150% and at or below 200% of the FPL.
- For children under 1 year of age, the adjusted gross income must be above 185% and at or below 200% of the FPL.

Chapter VI provides further detail on calculating the adjusted gross income.



VERIFICATION:

All income (earned and unearned) of the fiscal group must be reported on the application. Self declaration of income by the applicant must include the payee's name and the gross amount of monthly income.

NOTE: If the responsible parent/guardian receives child support on behalf of the child, then this amount must be considered as income for the child.

Excluded Income

The following income must not be used to determine *MIChild* eligibility:

- Earnings of a child under age 19, if the child is living with a relative who provides care and supervision.
- Supplemental Security Income (SSI) benefits. (Anyone receiving SSI is automatically eligible for Medicaid. That person, but not his income, should be included in the fiscal group for budgeting purposes.)
- Certain payments to Native Americans. Appendix C provides a list of public laws involving payments to Native Americans.

PREMIUMS

The premium is $5.00 per family per month, regardless of the number of children in the family. (Chapter VII, PREMIUMS, contains more information regarding premium payment.)

NONFACTORS

The following must <u>not</u> be a factor in determining *MIChild* eligibility:

- Disability status
- Pre-existing condition
- Diagnosis

EXCLUDED CHILDREN

Individuals who are not eligible for *MIChild* include:

- Children who are eligible for Medicaid (even if not yet enrolled in Medicaid). (Chapter II, SPECIAL POPULATIONS, contains more information on newborns, spend-down beneficiaries, and Medicaid.)

- Children who have been criminally adjudicated and are in a correctional facility, including a detention home or training school.
- Children who are admitted to an institution for the mentally disabled (e.g., ICF/MR).
- Children who are eligible for health insurance coverage on the basis of a family member's active permanent employment by a state, county, or city government agency in Michigan. School employees are not considered government employees.
- Children who are covered by court-ordered medical insurance. (Chapter II, SPECIAL POPULATIONS, contains more information on this situation.)
- Children who have been disenrolled from *MIChild* for failure to pay *MIChild* premiums. Applicants will not be eligible for coverage until the seventh month after the disenrollment for nonpayment of premiums. Applications received within 90 days of the eligible month will be processed for coverage, if otherwise eligible, beginning the seventh month. NOTE: Any remaining months in the disqualification period will be waived if any family member received Medicaid for at least one month since the closure of the *MIChild* case.
- Children whose families have had comprehensive employer-based health insurance in the past six months, regardless of the cost. See Chapter XIII, "Non-Voluntary Loss of Insurance." Applicants will not be eligible for coverage until the seventh month after the employer-based coverage ends. Applications received within 90 days of the eligible month will be processed for coverage, if otherwise eligible, beginning the seventh month.

EXCEPTION PROCESS

If there are special circumstances or questions regarding an applicant's *MIChild* eligibility, the Department will provide guidance with eligibility determination.

The health plans should contact the Administrative Contractor for assistance.

The Administrative Contractor should contact the Department for assistance.

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An application to enroll may be submitted to either the participating health plan or directly to the Administrative Contractor. Chapter V provides instructions for completion. If applications are received elsewhere (FIA, doctor's office, etc.), they must be forwarded to the Administrative Contractor.

LOCAL AGENCIES

The Department may contract with local agencies to provide outreach for *MIChild*. These agencies will provide information regarding *MIChild,* including eligibility criteria, the application process, and coverage.

These agencies will have applications available at their offices and provide assistance with completion of the applications. They may also provide assistance with the necessary verifications required for *MIChild.* Applications must be forwarded to the Administrative Contractor.

HEALTH PLANS
Initial Determination of Eligibility

A health plan that contracts with the Department to provide *MIChild* coverage may determine initial eligibility, upon approval by the Department. Final authorization of *MIChild* eligibility is the responsibility of the Department. (It should be noted that the health plan must determine if the child may be eligible for Healthy Kids prior to the initial determination of *MIChild* eligibility. Health plans approved to make initial eligibility recommendations must maintain an error rate of no more than 3%, and must determine initial eligibility for all *MIChild* applications.)

The health plan will review the application. If the application is unsigned or not fully completed, or required verifications are not present, the application is considered incomplete. The health plan may assist the applicant with this completion process.

Initial determination of eligibility must be made within two (2) working days of receipt of the completed application. Initial determination of eligibility will consist of:

- Reviewing and approving, if eligible, the completed application. The application must indicate the family's choice of health AND dental plans to be considered a complete application.

- Contacting the Administrative Contractor to determine if the applicant had previously been enrolled in *MIChild* and was

disenrolled for failure to pay premiums. Applicants will not be eligible for coverage until the seventh month after the disenrollment for nonpayment of premiums. Applications received within 90 days of the eligible month will be processed for coverage, if otherwise eligible, beginning the seventh month.

- Verifying that the applicant is not currently enrolled in, or appears to be eligible for, Medicaid or other federal-state programs.
- Determining the adjusted gross income, according to Chapter III, ELIGIBILITY CRITERIA.
- Comparing the adjusted gross income with the federal poverty level in Appendix B.
- Enrolling the child in a health plan, if eligible, effective the date eligibility was determined.
- Providing the family with a notification that the health plan has determined initial eligibility for *MIChild* and the effective date of enrollment.

The health plan must forward completed applications showing the effective date of the initial eligibility and eligibility verifications within two (2) work days of initial eligibility determination to the Administrative Contractor.

DENTAL PLANS

Dental plans, community mental health services programs, and coordinating agencies may not recommend eligibility for *MIChild.*

ADMINISTRATIVE CONTRACTOR
Recommendation of Eligibility

APPLICATIONS SENT BY THE APPLICANT DIRECTLY TO THE ADMINISTRATIVE CONTRACTOR

Applications may be sent directly to the Administrative Contractor for approval. In this situation, any required verifications must be attached to the application. If the applicant has not selected a health or dental plan, BC/BS will be selected for the applicant as the health plan, and Delta Dental will be selected for the applicant as the dental plan. Completed applications must be reviewed within ten (10) work days of receipt. The day the application is received is the first day of this 10 work day period. Beginning the day the materials are received to

make the application complete, a decision on eligibility must be mailed to the family's address via first class mail before the close of business on the tenth (10th) work day. The Administrative Contractor must follow-up with applicants filing incomplete applications.

The Administrative Contractor must determine if the applicant had been previously enrolled in *MIChild* and was disenrolled for failure to pay premiums. Applicants will not be eligible for coverage until the seventh month after the disenrollment for nonpayment of premiums. Applications received within 90 days of the eligible month will be processed for coverage, if otherwise eligible, beginning the seventh month.

The Administrative Contractor verifies any required documents and makes an eligibility recommendation to the Department of Community Health for *MIChild*. A Department employee will make the final determination of *MIChild* eligibility. Notice of approvals/disapprovals will be mailed by the Administrative Contractor to the family.

APPLICATIONS RECEIVED FROM THE HEALTH PLANS

Applications received from a health plan must be reviewed by the Administrative Contractor within the same ten (10) work day time frame as noted above unless the child was initially determined eligible by the health plan. If initial eligibility was granted, the application must be reviewed and a final eligibility decision made before the 15th of the month following the month in which initial eligibility was granted. This time frame includes the Department's approval of the application.

- If the application is approved, the family, CMHSP, Coordinating Agency (CA), health and dental plans must be notified, in writing, by the Administrative Contractor that *MIChild* eligibility has been approved effective the day the health plan approved the application.

- If the application is denied, the letter to the family must clearly state the reason for the denial and the family's right to request a Department Review of the denial. If initial eligibility was granted by the health plan, the family must be notified of the date that initial eligibility ends. A copy of the letter is sent to the CMHSPs, CAs, and the health and dental plans.

APPROVAL LETTERS

Approval notices must include:

- the applicant's name and address
- the begin date of *MIChild* eligibility
- annual redetermination date
- information regarding payment of the premiums
- the health and dental plans the family has chosen, including the phone numbers
- CMHSP, CA and substance abuse information
- Notice of changes which must be reported in writing to *MIChild* within 10 days of the change, including change of address, receipt of Medicaid, or the only beneficiary leaves the home or dies.
- the Department of Community Health nondiscrimination statement, and
- the statement "If you do not understand this form, please contact 1-888-988-6300" in English, Arabic and Spanish.

DENIAL NOTICES

Denial notices must state:

- the applicant's name and address
- the reason for denial of eligibility
- legal base for denial (i.e., Title XXI of the Social Security Act, as amended)
- if initial eligibility was granted by the health plan, the notice that initial eligibility is no longer in effect, the date the initial eligibility ends, and *MIChild* coverage is terminated
- Department Review rights, and include a Department Review form and envelope
- the Department of Community Health's nondiscrimination statement, and

- the statement "If you do not understand this form, please contact 1-888-988-6300" in English, Arabic and Spanish.

DEPARTMENT OF COMMUNITY HEALTH

All applications will be reviewed by the Department of Community Health for final determination of *MIChild* eligibility. If the Department determines that the child did not meet *MIChild* eligibility criteria, the Department will notify the Administrative Contractor, and the Administrative Contractor will notify the family and providers with the information noted above.

BEGIN DATE OF ELIGIBILITY

The begin date of eligibility for *MIChild* will depend on the following:

- If the health plan makes an initial determination of eligibility, *MIChild* eligibility begins the actual day the health plan approved the application.

- If the health plan does NOT make an initial determination of eligibility, *MIChild* eligibility begins the first day of the month following the month of approval. **NOTE:** If the application is approved within five work days of the beginning of the next month, the eligibility is effective the first of the following month. For example, if the application is approved May 28th, the effective date is July 1.

- If the applicant has had comprehensive, employer-based insurance coverage within the past six months, coverage may begin the month after the six-month penalty ends. See Chapter III for information on eligibility criteria.

- If the applicant was most previously disenrolled for failure to pay the *MIChild* premium, a six-month penalty is imposed. Coverage may begin the month after the six-month penalty ends. See Chapters III and VII for disenrollment information due to nonpayment of premiums.

The dental, CA and mental health coverage will begin the same date.

Inpatient Hospitalization

There may be instances involving an inpatient hospital admission.

- If *MIChild* eligibility begins while a beneficiary is in the hospital, the health plan is reimbursed for a full month of service. The

health plan is not responsible for services rendered while the beneficiary was in the hospital, as the health plan did not authorize the hospitalization. The health plan is responsible for all medically necessary services once the beneficiary is discharged.

- If *MIChild* health plan coverage ends while a beneficiary is in the hospital, the health plan is reimbursed for a full month of service. The health plan is responsible for services rendered while the beneficiary was in the hospital, as the health plan authorized the hospital stay.

ENROLLMENT IN HEALTH AND DENTAL PLANS

Enrollment in participating health and dental plans will be the responsibility of either the health and dental plan or the Administrative Contractor, depending on who makes the initial eligibility determination.

- The *MIChild* application may be received from the health and dental plan's initial determination of eligibility. If that health and dental plan is chosen, the health and dental plan will be responsible for enrolling the beneficiary in its health and dental plan. If a different health and dental plan is chosen, the application is to be referred to the Administrative Contractor for enrollment into the chosen health and dental plan. The Administrative Contractor is responsible for enrolling the beneficiary in the health and dental plan. The health and dental plans will refer beneficiaries to CMHSPs and CAs.

- If the *MIChild* application is received directly from the applicant or from an outside agency (e.g., schools, Tribal Health Centers), then the Administrative Contractor will be responsible for enrolling the beneficiary in the health and dental plan chosen by the family. Each health and dental plan, CMHSP and CA will be notified by the Administrative Contractor of new *MIChild* enrollees.

REFERRAL TO MEDICAID

The application must be reviewed for Medicaid eligibility prior to *MIChild* eligibility approval.

CHANGES IN FAMILY STATUS

If the family has applied for *MIChild* but has been determined ineligible, the children may be enrolled in *MIChild* any time a change occurs that makes a child eligible for *MIChild*. This could include a change in family size, loss of a job, or change in family income. (A change in the child's health status does not make a child eligible for *MIChild.)* If a family has a change in status that makes the children newly eligible for *MIChild*, the family should reapply as soon as possible.

ENROLLMENT LOCK-IN

The *MIChild* beneficiary is "locked-into" a health/dental plan for 12 months from the date of enrollment, as long as the child remains *MIChild* eligible. Beneficiaries have the first 30 calendar days of that period to change health/dental plans.

A beneficiary may change health/dental plans for cause, at any time, as determined on an individual basis and approved by the Department.

ANNUAL REDETERMINATION OF ELIGIBILITY

Eligibility determinations will be done annually. The Administrative Contractor must provide the family with redetermination forms for *MIChild* 30 work days prior to the end of the beneficiary's eligibility year. Effective August 1, 2000, the redetermination form lists the eligibility information the Administrative Contractor has on file. If no changes have occurred, the beneficiary signs and returns the redetermination form, indicating no changes have occurred. *MIChild* eligibility will continue as long as the premiums continue to be paid for the next year. If changes have occurred, the beneficiary must return the redetermination form with changes noted and required documentation, if any, within ten days from the date of the redetermination notice. Each individual's eligibility will be redetermined.

If the redetermination form is returned indicating a change of information, but is incomplete, the family will be notified of the required documentation needed, following the time frames specified for original applications. The Administrative Contractor will follow-up with the family, either by telephone or in writing. Failure of the family to complete the redetermination process will result in disenrollment from *MIChild* effective the last day of the enrollment year.

Post-eligibility audits will be done from a random sample of application and redetermination approvals. If the audit results in loss of *MIChild* eligibility, or if the family fails to cooperate with the audit process, *MIChild* benefits will terminate. See Post-Eligibility Audit Process, Chapter XII.

The Administrative Contractor uses the same forms for approval/denial notices as for initial determinations.

GENERAL INFORMATION

The DCH-0373-D, *MIChild*/Healthy Kids Application, is used to apply for *MIChild* benefits. NOTE: If applying at the Family Independence Agency (FIA), the FIA-1171 may be used to apply for *MIChild*/Healthy Kids. The DCH-0373-D form may be completed by anyone, but must be signed by the applicant. It should be completed in ink and in English. The current version of the form should be used. Dates should be entered in the MM/DD/YYYY format. Telephone numbers must include the area code.

If an item does not apply, the applicant should enter N/A.

PAGE 1

The top portion of the application provides basic information about *MIChild* and Healthy Kids programs. This page also requires information about the adults in the household.

Choice of Health Plans

Choosing health and dental plans is required for *MIChild.* If the children are eligible for Healthy Kids, the family will be contacted by the Administrative Contractor to verify their choice of health plan prior to enrollment. Dental coverage is provided through dental plans in some counties for Healthy Kids. If the applicant has not selected a health or dental plan, BC/BS will be selected for the applicant as the health plan, and Delta Dental will be selected for the applicant as the dental plan. NOTE: Pregnant women do not need to choose a health plan.

Identification of the primary care physician will assure continuity of care for the children assuming the primary care physician is participating in a *MIChild* health plan.

Adult's Information

If there are more than two adults in the home, additional pages must be included with the application. Each additional adult must include his first, middle, and last name; and his relationship to each child. Each adult is asked to list his primary language. Additional pages must include the applicant's original signature. Pregnant women complete the appropriate column on Page 2.

PAGE 2

This page requests information on all children or pregnant women, including each child's or pregnant woman's primary language and relationship to each adult listed on page one, as well as citizenship status.

If there are more than three children living in the home, additional pages must be included with the application. The additional information must include each first, middle, and last name, primary language and the relationship of the child to each adult. Additional pages must include the applicant's original signature.

Social Security Number (SSN)

A SSN or an application for a SSN is required for each person who wishes to receive medical coverage. If a SSN is not available, the applicant should be given an SS-5, Social Security Number Application, to request an SSN, or be directed to the local Social Security Administration for assistance.

Children's Information

All children in the home must be listed for budgeting purposes.

Completion of the racial/ethnic information is voluntary.

If a child does not have an SSN, the applicant should be given an SS-5 to apply for the SSN.

If a child is not a citizen of the United States, a copy of the front and back of the I-551 or I-94 must be obtained.

Many of the questions on this page are self-explanatory. Only those questions that may need clarification are listed below.

Health Insurance Questions

These questions should be answered "yes" only if any of the children are currently receiving benefits under any health insurance. While coverage through a parent's employer usually makes a child ineligible for *MIChild*, the information is required for Healthy Kids.

Catastrophic coverage, or specialty coverage such as dental only, is not considered comprehensive health insurance coverage.

Past Medical Bills Questions

This information is required to determine possible retroactive coverage for Healthy Kids. Pregnant women are automatically enrolled for three months of retroactive coverage. The retroactive

health services must be for unpaid medical expenses. There is no retroactive coverage for *MIChild*.

PAGE 3

This page requests income information for all persons in the home. Gross and net income information must be reported. Self-employed persons should list allowable deductions. Persons with rental income should include an explanation of their expenses for the rental property. Further explanation of income reporting may be found in Chapter VI, Eligibility Determination.

PAGE 4

This page includes important information regarding the rights and responsibilities of applicants, nondiscrimination information, notice requirements, and the applicant's signature.

Signature

Prior to signing the application, and additional sheets if necessary, the applicant should read the information regarding release of information, use of this application for Medicaid purposes, subrogation, discrimination, and pursuit of financial or medical support for children.

If health and dental plans are not chosen by the applicant, plans will be selected for them. (See "Choice of Health Plans" earlier in this chapter.) The application is not considered until the application is signed.

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GENERAL INFORMATION

MIChild eligibility is determined using the DCH-0373-D, *MIChild*/ Healthy Kids Application. The FIA-1171 application may be used by FIA . The information contained on the application and supporting verifications, as specified, include all the information needed to determine eligibility.

If the application is incomplete, or verifications need to be obtained, the health plan and/or Administrative Contractor must request such information in writing from the applicant. The applicant has 30 calendar days from the date of notification to provide the needed information, or the application will be denied.

HEALTHY KIDS

Eligibility for Healthy Kids (Medicaid) must be determined prior to consideration of *MIChild* eligibility.

Once the child has been determined NOT eligible for Healthy Kids, *MIChild* eligibility may be determined as follows.

NONFINANCIAL FACTORS

There are several nonfinancial factors that must be documented, either by separate document or by the applicant's statement. These factors include:

- citizenship/alien status
- residency
- Social Security Number
- age
- health insurance coverage.

Chapter III provides further information regarding these factors.

GROUP COMPOSITION (INCOME GROUP)

The group composition for *MIChild* is the same as for Healthy Kids.

FINANCIAL FACTORS

As indicated in Chapter III of this manual, the adjusted gross income for *MIChild* must be above 150% and at or below 200% of the FPL, depending on the child's age. See Appendix B.

The adjusted gross income is determined for the month that eligibility will begin. For example, if the application is received directly by the Administrative Contractor in June, then eligibility cannot begin until July. Therefore, the monthly budget should be determined for July.

Budgets will always be determined using a four-week month, even if there are really five weeks in the month being determined.

The adjusted gross income is calculated by adding the countable income, applying the appropriate deductions and computing the distribution of the income. The resulting figure must be compared to the FPL's in Appendix B to determine if the income level meets *MIChild* eligibility criteria.

Countable Income

Effective August 1, 2000, self-declaration of income is allowed for applicants using the DCH-0373-D application. The following items must be used to determine the family's income for *MIChild* eligibility purposes:

- All income (earned and unearned) of the fiscal group. Self-declaration of monthly income by the applicant must include the payee's name.
- RSDI (Retirement, Survivors and Disability Insurance) benefits. (If a family member receives RSDI, then so do all of his dependents.) Self-declaration of the gross monthly amount is used.
- Self-employment income - The family's self-declaration of monthly income and deductions, on a monthly basis, will suffice.
- Unearned income received by the children applying for, or receiving, *MIChild* and that children's relatives who live with the children (e.g., child support, Social Security benefits) is included in the self-declaration of income section of the application.
- Income from rental property. Self-declaration of the gross monthly rental income amount is used.

If any relative in the applicant's family has a garnishment of wages, the full wages (before garnishment is deducted) are counted as income.

Income Deductions

The following should be deducted:

- a standard work expense of $90 from the countable earnings of each person who is working.
- a deduction of $30 plus 1/3 of a fiscal group member's remaining earned income if the member received FIP cash assistance or Low Income Family medical coverage from the FIA in at least one of the four calendar months preceding the month of the eligibility budget.
- child care payments. Effective July 1, 2000, a standard $200 is deducted monthly per child for which the applicant claims a child care expense, regardless of the actual amount of the expense. The Child Care Section (below) provides details on determining who is eligible for this deduction.
- a deduction of $50 from the total child support received for each child.
- 65% of rental income may be deducted for administrative purposes, or the actual rental expenses if the landlord claims a larger expense.
- operating expenses, based on the family's statement for self-employed persons. (Depreciation; net loss; federal, state, and local income taxes; personal business expenses including entertainment and retirement funds are NOT considered deductions.)
- court-ordered child support paid by a fiscal group member for a child who does not live with the fiscal group. Arrearage payments are NOT deductible.
- Effective July 1, 2000, a standard deduction of $60 from guardianship/conservator fees paid.

Child Care

Child care (dependent care) may be deducted only if the following are met:

- the child must be living with the family member who is paying for the care
- the child must be that family member's child
- the child must be under age 15, or under age 18 and need care because of a mental or physical limitation
- the other parent is not available to provide the day care due to conflicting work, school or training schedules.

NOTE: if the family has **any** monetary obligation for child care for an eligible child, the full $200 child care deduction is budgeted as an expense. If the **full** amount of the child care is paid by another entity (e.g., FIA, grandmother), the child care deduction cannot be allowed. Example: the child has a child care expense of $300 monthly. FIA pays $150 of this care. Because the family has an obligation to pay the balance of the child care, the full $200 deduction is allowed. If the entire $300 was paid by FIA, no deduction would be allowed.

Add the total allowable child care deduction to get each family's total deduction for child care. This total amount is used as the child care deduction for each child's budget.

ELIGIBILITY CERTIFICATION (MSA-0853)

The MSA-0853, Eligibility Certification, is a worksheet which is available for determining the financial eligibility of a *MIChild* applicant. The form is also available electronically from the Intranet site of the Department.

HEALTHY KIDS: The MSA-0853 may be used for eligibility determinations for Healthy Kids and *MIChild.* Healthy Kids eligibility MUST be determined prior to any determination of *MIChild* eligibility. For Healthy Kids, the group composition is the same as for *MIChild*, therefore, a budget needs to be determined for each child in the family. The Program Eligibility Manual for Medicaid contains the guidelines to be used to determine Medicaid eligibility. Once Healthy Kids eligibility is ruled out, then *MIChild* eligibility may be determined using the same form.

MIChild: The group composition for each child in the family is the same as for Healthy Kids (e.g., child, mother, and father).

The MSA-0853 includes a space to add the income limits for reference. These income limits are included in Appendix B of this manual. This form is to be used in conjunction with this manual.

- Income is to be entered in monthly amounts.
- Eligibility recommendations for Healthy Kids or *MIChild* should be entered.
- Status of the application should be noted.
- The signature must be left blank. DCH staff approves eligibility.

Eligibility Certification MSA-0853

MIChild / Healthy Kids
ELIGIBILITY CERTIFICATION

Michigan Department of Community Health
Medical Services Administration

Case Name
Case Number

	Healthy Kids	MIChild
Income Limit ▶	$	$
Number in Income Group ▶		
1. Earned Income	$	$
2. Minus $90 deduction	$ 90.00	$ 90.00
3. **Subtotal:** (line 1 minus line 2)	$	$
4. 30 1/3 Disregard (if eligible)	$	
5. **Subtotal:** (line 3 minus line 4)	$	$
6. Dependent Care Deduction *(see worksheet below)*	$	$
7. **Subtotal:** (line 5 minus line 6)	$	$
8. Child Support Income	$	$
9. Minus $50 deduction	$	$
10. Line 8 minus line 9	$	$
11. **Subtotal:** (line 7 plus line 10)	$	$
12. Other Unearned Income	$	$
13. **Subtotal:** (line 11 plus line 12)	$	$
14. Court Ordered Support / Guardian Fees Paid	$	$
15. **Gross Eligibility Income:** (line 13 minus line 14)	$	$

DEPENDENT CARE DEDUCTION:

CHILD'S NAME	$200 per Child
TOTAL ▶	$

Eligibility for:
☐ **Healthy Kids** ☐ **MIChild**

Comments:

Eligibility Determination:
☐ **Pended** ▶ Date: _____ Reason: _____

☐ **Approved** ☐ **Denied** ▶ Reason: _____

DCH Approval Signature: Date:

MSA-0853 (Rev. 3/01) (W) Previous Edition Obsolete

DETERMINATION

If the child has met all nonfinancial and financial factors for eligibility, then the child is eligible for *MIChild.*

HEALTH PLANS

All applications, both denied and approved, and appropriate verifications must be sent to the Administrative Contractor. The health plans should keep a copy of the application and all documentation in the child's record.

ASSESSMENT OF PREMIUMS

MIChild families will be assessed a premium of $5.00 per family per month, regardless of the number of children in the family. The family is responsible for payment of the premium each month. NOTE: effective for July 2001 *MIChild* premium payments, American Indians and Alaska Natives are exempt from the $5.00 per month premium. The family is exempt from payment if any family member listed on the application and living in the household is an American Indian or Alaska Native, even if that member is an adult or a Medicaid recipient.

ADMINISTRATIVE CONTRACTOR RESPONSIBILITY

The Administrative Contractor is responsible for collecting the appropriate premium amount each calendar month. It is the Administrative Contractor's option, with the family's concurrence, to obtain the premium on a monthly, quarterly, yearly basis, or by some other payment arrangement.

The Administrative Contractor will send the family a yearly coupon booklet for premium payment purposes. There will be one coupon for each month the premium is due.

If the health plan provides an initial determination of *MIChild* eligibility, then the full premium for that child should be collected beginning with the first full month of eligibility. For example, if the applicant was initially determined eligible for *MIChild* on January 21st, the first premium would be due for February coverage. The Administrative Contractor collects the February premium from the family. The premium and the coupon are to be sent to the Administrative Contractor.

FAILURE TO PAY PREMIUMS

If the family fails to pay the appropriate premium, the family has until the 20th of the month for which the premium was due to make the payment. Premiums that are U.S. postmarked by the 20th of the month will be accepted as timely. If the 20th of the month is not a workday, the due date wiill be the next business day following the 20th. *MIChild* eligibility and coverage will continue for that month. For example if during the month of January, the family did not pay the premium for February the premium must be U.S. postmarked by February 20th for *MIChild* benefits to continue past the last day of February.

The Administrative Contractor will notify the family, in writing, of:

- the amount due
- the date the past due premium must be paid
- the beneficiary's disenrollment from the health plan if the past due premium is not paid
- the date coverage will end
- the need to report any change in circumstances (for example: loss of income, additional family members, or requirement to pay child support for a child not living with the family) which may result in a new determination of eligibility
- the right to request a Department Review and the procedures to follow in requesting a Department Review.

Failure to pay the monthly premium will result in disenrollment from *MIChild* effective the first day of the following month for which the premium was due.

If the applicant is disenrolled for failure to pay the *MIChild* premium, a six-month penalty is imposed. Coverage may not begin until the month following the end of the six-month penalty period. See Chapter III, Excluded Children, for disenrollment information due to nonpayment of premiums.

GENERAL INFORMATION

It is the Administrative Contractor's responsibility to disenroll the beneficiary from the health plan.

The health plan is responsible for the beneficiary's medical care until the Administrative Contractor notifies the health plan that its responsibility for the beneficiary has ended. This notification will be in a form agreeable to both the health plan and the Administrative Contractor.

RETROACTIVE DISENROLLMENT

The Administrative Contractor must not retroactively disenroll any beneficiary unless the beneficiary died before the beginning of the month in which the capitation payment was made.

DISENROLLMENT FROM *MICHILD*

Enrollment in *MIChild* is for one year, except in the following situations that result in immediate loss of *MIChild* eligibility.

- Nonpayment of premiums. The effective date of disenrollment is the end of the month for which the premium was due. The disenrollment period is six months.
- Loss of *MIChild* eligibility due to admission to a correctional facility or an institution for the mentally disabled (ICF/MR). The effective date of the disenrollment is the end of the month of admission to the institution.
- Family/child moves from the state. The *MIChild* beneficiary must be disenrolled from the health plan effective the last day of the month that the child resided in Michigan.
- Death of a *MIChild* beneficiary. The effective date of disenrollment will be the date the beneficiary died.
- A *MIChild* beneficiary becomes active Medicaid before annual redetermination. A *MIChild* beneficiary may not receive *MIChild* and Medicaid for the same coverage period. The effective date of disenrollment is the end of the month prior to the month of enrollment in the other program.

- If a change is reported in writing that results in disenrollment from *MIChild,* the child will be disenrolled effective the month following receipt of the written notification, if the notification is received by the enrollment cut-off date. Refund will only be made for months *MIChild* coverage does not exist.

- Beneficiary meets a Medicaid spend-down during a month *MIChild* is active. The beneficiary is not disenrolled; MSA will reconcile the payments in an internal process.

- Beneficiary turns age 19. The effective date of disenrollment is the last day of the month in which the person turns age 19.

The following is a reason for disenrollment at annual redetermination:

- Loss of *MIChild* eligibility due to eligibility for other programs (e.g., Medicaid), other insurance coverage, income in excess of *MIChild* limits, failure to complete redetermination forms or failure to provide required verifications. The effective date will be the last day of the enrollment year for the beneficiary.

The Administrative Contractor must provide the family with a creditable certificate of coverage upon disenrollment from *MIChild.*

DISENROLLMENT FROM THE HEALTH PLAN

Reasons for disenrollment from the health plan include:

- Family/child moves from the health plan's service area. The *MIChild* beneficiary must be disenrolled from the health plan effective the first day of the month following the Administrative Contractor's implementation of the change of address. The health plan remains responsible for services until the effective date of disenrollment.

- Improper actions on the part of the beneficiary/family that are inconsistent with the health plan membership, including fraud, abuse of the health plan, or other intentional misconduct; or if, in the opinion of the health plan, the beneficiary's/family's behavior makes it medically infeasible for the health plan to safely or prudently render covered services to the beneficiary. Such termination is subject to the written grievance procedures of the health plan, except that the notice of termination must be immediately communicated to the beneficiary/family, along with

the procedures for expeditious review. The health plan must contact the Administrative Contractor and supply supporting documentation of the possible disenrollment. The Administrative Contractor will review the documentation and make a recommendation to the Department. The Department must approve the disenrollment. The effective date will be the last day of the month the Department approves the disenrollment.

- The health plan's contract with the Department is terminated for any reason. The effective date of disenrollment is the date the contract is terminated.

GENERAL INFORMATION

Requests for Department Review, complaints, and grievances regarding **eligibility** for *MIChild* should be resolved as follows:

- If the family appeals a denial of initial eligibility made by the health plan, the appeal should be resolved through the health plan, if possible.
- The Administrative Contractor is available if resolution through the health plan is not possible.

The applicant/family also has the right to appeal directly to a Department Review without appealing to the health plan or Administrative Contractor first.

Complaints, grievances, and requests for Department Review regarding services or other actions taken by the health plan must be resolved by the health plan and, if necessary, the Department's Department Review process or the Department of Consumer and Industry Services Insurance Bureau.

REQUESTS FOR DEPARTMENT REVIEW

The family must be notified of the eligibility decision as indicated in Chapter IV, Application Process. Included with the notification is the family's right to request a Department Review, and the Department Review request form. The family has the right to appeal the eligibility decision made by the Department.

Health Plan

If the family wishes to appeal the health plan's initial determination of eligibility, the family should first try to resolve the issue with the health plan. Many times, additional documentation or a verbal clarification of an issue may resolve the matter.

If the issue cannot be resolved by the health plan, the family has the right to request that the application be immediately reviewed by the Administrative Contractor. Unresolvable issues at the Administrative Contractor level must be referred to the Department for resolution through the Department Review process.

The Department, through the Administrative Contractor, must notify the family of the Department's decision regarding *MIChild* eligibility.

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GENERAL INFORMATION

The Department contracts with licensed dental managed care entities to provide dental services to *MIChild* enrollees. These entities are responsible for providing the *MIChild* covered services for a per member per month capitation rate.

ELIGIBILITY

The dental contractor cannot determine initial eligibility for *MIChild.* Eligibility will be determined as described in Chapter IV, Application Process.

Once the application is forwarded to the Administrative Contractor and eligibility is verified, the Administrative Contractor will notify the dental plan that the child is enrolled and the effective date of enrollment. This notification must be within the ten (10) day period that the Administrative Contractor has to review the application.

The effective date of enrollment will be the same as for the health plan. The dental plan should refer to Chapter IV, "Application Process, Begin Date of Eligibility" for more information.

ENROLLMENT

The child must be enrolled in the dental plan in order for services to be covered. The Administrative Contractor enrolls the child in a dental plan of the family's choice.

LOSS OF ELIGIBILITY DURING TREATMENT

Certain procedures that were started before the loss of eligibility may be covered provided that the services were completed within a 60-day period from the date of loss of eligibility.

The dental capitation that was paid to the dental contractor covers the completion of these services. The child's family must not be billed for these services.

No capitation payments will be made once *MIChild* eligibility ends.

DISENROLLMENT

The Administrative Contractor must notify the dental plan of any disenrollments in *MIChild*. The effective date of disenrollment will be the same as for the health plan. The dental plan should refer to Chapter IV, Application Process, Disenrollment for more information.

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GENERAL INFORMATION

The Department contracts with the CMHSPs and CAs to provide mental health and substance abuse services to *MIChild* enrollees. These entities are responsible for providing the *MIChild* covered services for a per eligible per month capitation rate.

ELIGIBILITY

CMHSPs and CAs cannot determine initial eligibility for *MIChild.* Eligibility will be determined as described in Chapter IV, Application Process.

Once the application is forwarded to the Administrative Contractor and eligibility is verified, the Administrative Contractor will notify the CMHSP and CA that the beneficiary is enrolled in *MIChild* and the effective date of enrollment. The child is not enrolled in a CMHSP or CA.

The effective date of enrollment will be the same as for the health plan. The dental plan should refer to Chapter IV, Application Process, and Begin Date of Eligibility, for more information.

ENROLLMENT

The child is automatically eligible for *MIChild* covered mental health and substance abuse services authorized by the CMHSP or CA once *MIChild* eligibility is determined.

DISENROLLMENT

The Administrative Contractor must notify the CMHSP and CA of any *MIChild* disenrollment. The effective date of disenrollment will be the same as for the health plan. The CMHSP and CA should refer to Chapter IV, Application Process, Disenrollment, for more information.

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GENERAL INFORMATION

The Department will conduct random post-eligibility audits to ensure that *MIChild* eligibility has been granted appropriately.

ADMINISTRATIVE CONTRACTOR RESPONSIBILITY

The Administrative Contractor will forward to the Department, on a weekly basis, lists of all applications approved initially and at redetermination, and of all denied applications.

DCH RESPONSIBILITY

The Department will randomly select, from the lists described above, the names of case files selected for audit, and will request copies of these eligibility materials from the Administrative Contractor.

Upon receipt of these eligibility materials from the Administrative Contractor, the Department will review the materials and request documentation from the beneficiaries to substantiate the statements made on the application. This documentation may include copies of pay stubs, written verification from employers, income tax records of self-employed persons, documentation from Friend of the Court or court documents establishing guardianship fees.

The request for documentation will be made on the DCH-0956. The requested verifications must be returned to the Department, postmarked no later than 15 days from the date of the DCH-0956. Detailed instructions, including a telephone number to call for additional assistance, and a warning that failure to cooperate with the audit will result in immediate termination of MIChild benefits, are included on this form.

RESULT OF AUDIT

If the audit determination process results in confirmation of the original eligibility decision, the beneficiary will receive notice of the successful audit.

Other determinations that may result from the audit are:

- The child originally qualified for Healthy Kids Medicaid, not *MIChild,* or

NOTE: Children found eligible for Healthy Kids Medicaid will be terminated from the *MIChild* program, and will be enrolled in Healthy Kids Medicaid by FIA staff.

- The child did not qualify for *MIChild*, due to other insurance, excess income, or other eligibility factors.

NOTE: Children found not eligible for either *MIChild* or Healthy Kids Medicaid will receive notice that they will be terminated from the *MIChild* program. Included with the notification is the family's right to request a Department Review, and the Department Review request form. The family has the right to appeal the eligibility decision made by the Department.

DISENROLLMENT NOTICES

Notices of disenrollment from *MIChild* will include information that the child may reapply at a later date if the family situation changes and medical coverage is needed.

AUDIT REPORTS

Audit results will be provided on a regular basis and shared with *MIChild* staff for training purposes.

The following definitions should be used with the *MIChild* Eligibility Manual:

Abuse

Provider practices that are inconsistent with sound fiscal, business, or medical practices, resulting either in unnecessary cost to the Program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards of care.

Adjusted Gross Income

The amount of allowable income for the group minus allowable deductions.

Administrative Contractor

The entity that contracts with the Department of Community Health to provide administrative support for *MIChild*.

AFDS

Alternative Finance Delivery System. A category of licensure for prepaid limited health service organizations, such as dental and vision plans.

Applicant

An individual who has had an application for *MIChild* submitted on his behalf. (The person remains an applicant until *MIChild* is approved, denied, or the application is withdrawn.)

Beneficiary

A child enrolled in *MIChild*.

CA

The Coordinating Agency that provides substance abuse services to *MIChild* enrollees.

CMHSP

Community Mental Health Service Plan, which is the agency that provides mental health services to *MIChild* enrollees.

Certificate of Coverage

Written notification from the health plan of the coverages available under *MIChild.*

Certificate of Creditable Coverage

Written certification of 1) the period of creditable coverage for the person and the coverage, if any, under such COBRA continuation provision and 2) the waiting period, if any, imposed with respect to the person for any coverage.

CSHCS

Children's Special Health Care Services is a program established under Title V of the Federal Social Security Act, being 42 U.S.C. 701 to 716, and pursuant to Sections 5801 to 5879 of Act No. 368 of the Public Acts of 1978, as amended. The program provides specialty medical care and related services to persons under age 21 for certain severe and chronic medical diagnoses, and persons age 21 and over with Cystic Fibrosis or certain blood coagulation disorders.

Comprehensive Insurance

Insurance that covers inpatient and outpatient hospital services, laboratory, x-ray, pharmacy, physician services, etc. Catastrophic coverage, dental-only coverage, or emergency coverage only is NOT considered to be comprehensive insurance coverage.

Court-Ordered Medical Support

Comprehensive medical support ordered by the court as the result of a divorce, separation, paternity, etc.

Dental Plan

The nonprofit dental or health corporation, or dental AFDS that contracts with the Department of Community Health to provide dental services to *MIChild* beneficiaries.

Department

Department of Community Health and its designated agents.

Department Review

The process by which the department reviews complaints about denial of *MIChild* eligibility, and complaints and grievances about services or other actions taken by the health plan.

FPL

The Federal Poverty Level guidelines are a simplified version of the federal government's statistical poverty thresholds. The poverty guidelines, developed and released annually by the U.S. Department of Health and Human Services, are used as a criterion by many federal and state programs to determine whether applicants are financially eligible.

FIA

The Family Independence Agency.

Final Determination of Eligibility

The Department's determination, after review of the application verifications, of the applicant's eligibility for *MIChild*.

Fraud

Intentional deception or misrepresentation made by a person with the knowledge that the deception or misrepresentation could result in some unauthorized benefit to that person or another.

Group Composition

The fiscal group used to determine financial eligibility for a *MIChild* applicant.

Health Plan

Licensed health maintenance organizations, licensed insurers, and licensed nonprofit health care corporations that have contracted with the Department to provide services to *MIChild* beneficiaries.

Initial Determination of Eligibility

Process whereby the health plan determines probable eligibility for *MIChild* without actually approving the applicant's eligibility.

Locked-In

Beneficiary's inability to change health and dental plans until an open enrollment period.

Nonvoluntary Loss of Insurance

A loss of comprehensive health insurance coverage due to reasons beyond the family's control. This includes: the employer going out of business; the employee losing his job; the employer dropping comprehensive health insurance coverage for all dependents of the employee; the carrier no longer offering the comprehensive health insurance coverage. COBRA coverage may be dropped and *MIChild* benefits may begin immediately. There is no six-month wait in this case.

Premium

Monthly cost-sharing amount payable by the parent or other entity. It is considered to be one requirement for *MIChild* eligibility.

Recommendation of Eligibility

The Administrative Contractor's recommendation, after review of verifications, of the applicant's eligibility for *MIChild.*

Spend-down

A process which allows persons with excess income to become eligible for Medicaid if sufficient allowable medical expenses are incurred. Such persons must incur medical expenses each month equal to, or in excess of, an amount determined by the local FIA specialist to qualify for Medicaid. Once the spend-down amount has been met, there is Medicaid eligibility from the day the spend-down amount is met until the end of the month. (The *MIChild* premium may be used as an incurred expense.)

TMA-Plus

The Transitional Medical Assistance-Plus program operated by the State that allows persons losing transitional Medicaid or Michigan TMA coverage to buy-in to Medicaid, provided certain criteria are met.

Work Day

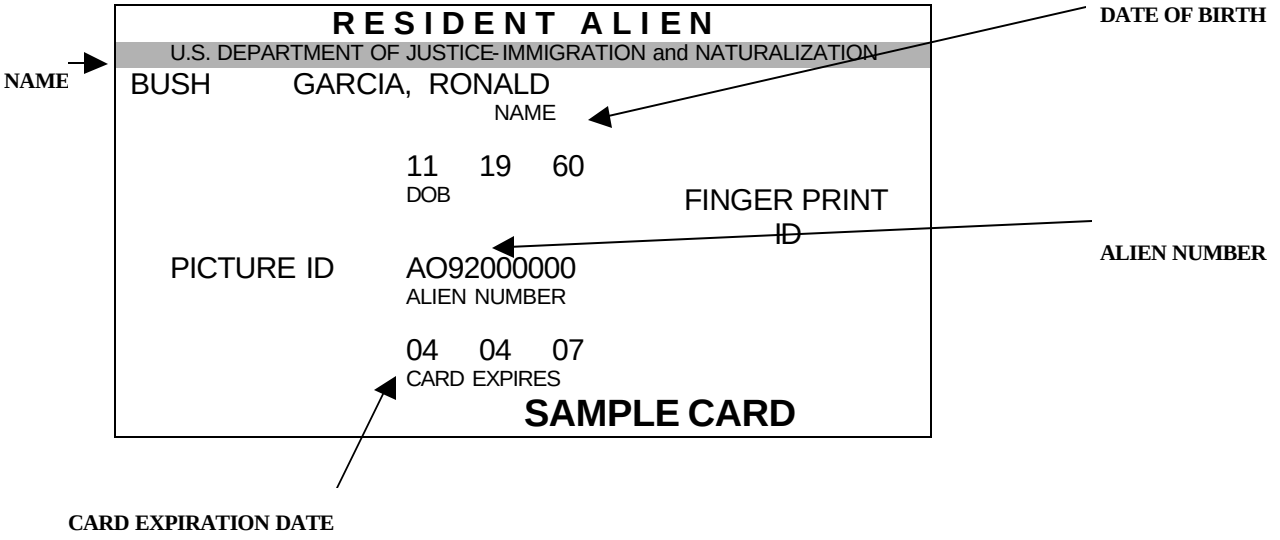
The same days of the week (Monday through Friday) that State employees must be at work. This excludes State-approved holidays.

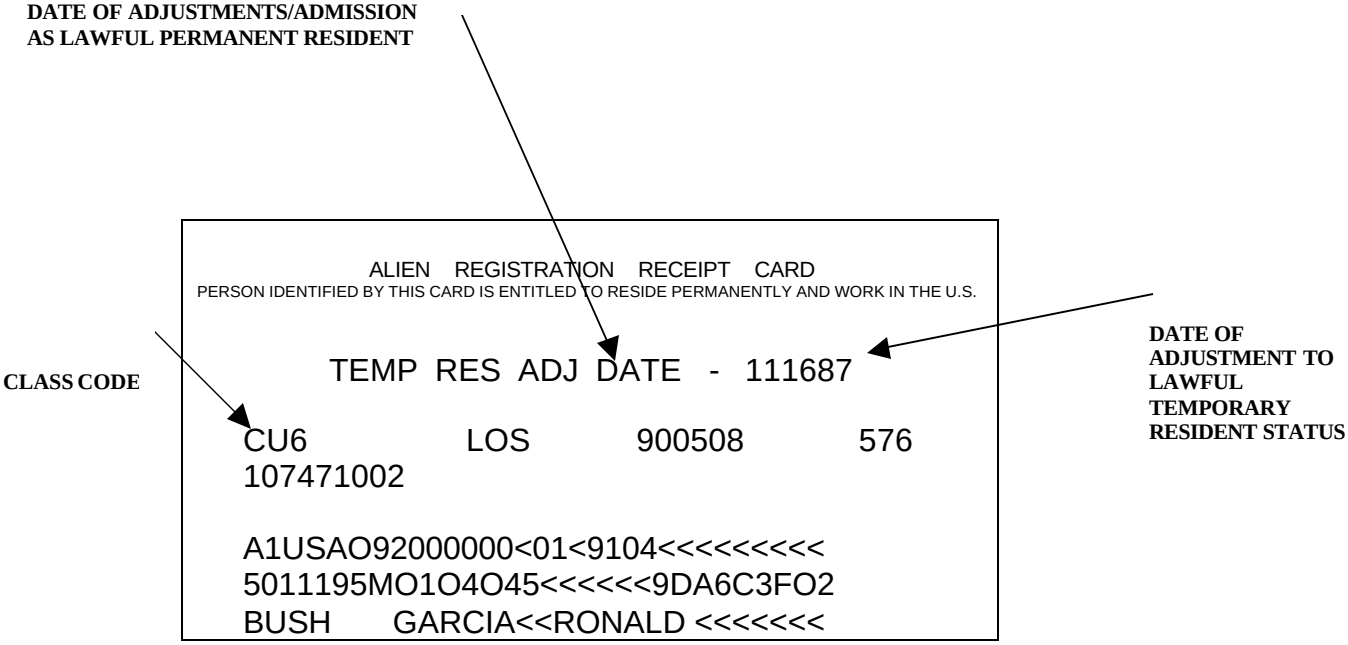
The following chart indicates if the child meets the citizenship criterion for *MIChild.* Eligibility as an alien is based on the codes on the I-551 (Alien Registration Receipt Card).

CITIZENSHIP/ALIEN STATUS	***MIChild* Eligibility**
U.S. Citizen (including person born in Puerto Rico)	YES
Person born in Canada , at least 50% American Indian	YES
Qualified Military Alien	YES
Spouse or Dependent Child of Qualified Military Alien	YES
Refugee under Section 207	YES
Asylee under Section 208	YES
Cuban/Haitian Entrant Class Code CR6, CU6, or CU7	YES
Amerasian Class Code AM	YES
Permanent Resident Alien Class Code RE or AS	YES
Permanent Resident Alien	
Class Code Other Than AM, AS, CR, CU, RE	
• U.S. Entry before 8/22/96	YES
• U.S. Entry on or after 8/22/96	
• First 5 years in U.S.	NO*
• More than 5 years in U.S.	YES
Permanent Resident Alien, has I-151	YES
Deportation (Removal) Withheld under Section 241(b)(3) or 243(h)	YES
Granted Conditional Entry under Section 203(a)(7)	YES
Paroled under Section 212(d)(5) for at least 1 year	
• U.S. Entry before 8/22/96	YES
• U.S. Entry on or after 8/22/96	
• First 5 years in U.S.	NO*
• More than 5 years in U.S.	YES
Paroled under Section 212(d)(d) for less than 1 year	NO
Nonimmigrant (e.g., student, tourist)	NO
Aliens not described above (e.g., illegal aliens)	NO

* Unless a qualified military alien, or the spouse or dependent child of a qualified military alien

The following is an example of the I-551, Alien Registration Receipt Card.





The following monthly income limits should be used in determining *MIChild* eligibility. They must be used for Medicaid coverage determinations. These limits are applied after allowable deductions from gross income figures.

Effective February 2002:

	MONTHLY INCOME		
Number in Family Group	Maximum Monthly Amount for HEALTHY KIDS 150% of Federal Poverty Level	Maximum Monthly Amount for HEALTHY KIDS for Ages 0 < 1 185% of Federal Poverty Level	Maximum Monthly Amount for *MIChild* 200% of Federal Poverty Level
1	$1,114	$1,374	$1,485
2	1,499	1,849	1,999
3	1,884	2,324	2,512
4	2,269	2,799	3,025
5	2,654	3,273	3,539
6	3,039	3,748	4,052
7	3,424	4,223	4,565
8	3,809	4,698	5,079
9	4,194	5,173	5,592
10	4,579	5,648	6,105
For each additional person add	$385	$475	514

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The following laws include reference to income by Native Americans that must be excluded from the determination of income.

- Public Law 92-203: Tax exempt portions of payments under the Alaska Native Claims Settlement Act
- Public Law 92-254: Judgment funds to members of the Blackfeet Tribe of the Blackfeet Reservation, Montana, and Gros Ventre Tribe of the Fort Belknap Reservation, Montana
- Public Law 93-134: Funds distributed to members of the Indian tribes and the purchases made with such funds. Also, exclude up to $2,000 per year of income received by an individual Indian that is derived from leases or other uses of individually-owned trust or restricted lands
- Public Law 93-531: Relocation assistance payments to members of the Hopi and Navajo Tribes
- Public Law 94-114: Receipts distributed to members of certain Indian tribes
- Public Law 94-189: Payments received under the Sac and Fox Indian agreements
- Public Law 94-540: Judgment funds to the Grand River Band of Ottawa Indians
- Public Law 95-433: Payments by the Indian Claims Commission to the Confederated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation
- Public Law 96-420, Section 5: Payments to the Passamaquoddy Tribe and the Penobscot Nation or any of their members received pursuant to the Maine Indian Claims Settlement Act of 1980
- Public Law 98-64: Funds distributed to members of Indian Tribes and purchases made with such funds
- Public Law 98-123: Funds distributed to members of the Red Lake Band of Chippewa Indians
- Public Law 98-124: Funds distributed to the Assiniboine Tribe of the Fort Belknap Indian Community and the Assiniboine Tribe of the Fort Peck Indian Reservation
- Public Law 99-346: Payments and distributions of judgment funds to the Saginaw Chippewa Indian Tribe of Michigan. May be called payments from the Investment Fund or Elderly Assistance Investment Fund.
- Public Law 105-143: This law provides funds to Ottawa and Chippewa Indians of Michigan.

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